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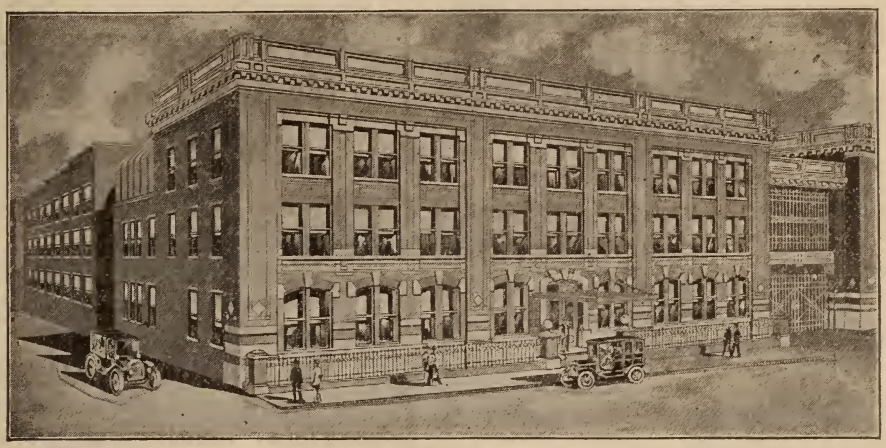

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THE ECLECTIC REVIEW

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VOL. XVIII. NEW YORK, JANUARY 15, 1914. No. 1

Hints and Winnowings.

Medical Practice of the Future is to be based upon the principles now governing Specific Medication. One has but to observe the present trend of medical thought in order to become convinced that this statement is already an assured fact. There is hardly an issue of the leading old school journals that does not contain one or more articles suggesting progress along this line. Physicians of all schools are beginning to realize that Specific Medication enables one to obtain better success in the treatment of the sick than has ever been secured through the means of any other system of therapeutics.

Specific Medication may not be an easy practice for those who are pleased to believe in a definite treatment arranged by some "authority" according to the name of the disease, for in the practice of this system of therapeutics each case is a study in itself and must be thoroughly worked out and divided into its component parts. This requires one to think hard and quickly, but when one becomes accustomed to such study it affords much pleasure and profit.

Even the *Journal of the American Medical Association,* in replying to a correspondent, recognizes the principles upon which Specific Medication is founded, when it says:

"A letter received by the Journal reads: 'What is the best treatment for diabetes mellitus?' That is all. There is nothing unique about the letter or the question; it is a sample of queries that come every few days, and illustrates the fact that some men are still treating names. There is a popular notion that a definite treatment has been laid down to correspond to every disease; one has but to apply the treatment prescribed in the textbook. The idea is crude and fallacious that when the diagnosis is made the treatment is easy, the fallacy arising from the fact that diagnostic analysis is not carried far enough and names alone suffice without a determina-

tion of the pathologic condition in all its details. Our present querist appears satisfied with the name 'diabetes,' qualified, to be sure, by the adjective 'mellitus.' A little reflection should indicate that this name includes a number of different conditions, the presence or absence of which must decide the plan of treatment to be adopted. Thus, diabetes patients differ much in their tolerance of carbohydrates. Some have acidosis and are threatened with coma; others are in no immediate danger. Before deciding on the treatment for any disease the actual conditions requiring relief must be determined, and then the appropriate remedy prescribed. In the case of diabetes it must be determined to what extent carbohydrates can be tolerated by the individual patient, as there may be present so great a degree of acidosis that to exclude carbohydrates would be dangerous. If the danger is from intoxication by sugar in the blood, the diet must be regulated to reduce the sugar to a minimum. If acidosis threatens, the proper remedies must be chosen to avert the danger. We are taking this particular letter and the disease it specifies to emphasize a principle, for the principle applies to other diseases—to all diseases, in fact. There is no specific treatment for typhoid fever, even the diet of a typhoid patient must vary according to conditions. The same is true of pneumonia; what will benefit one pneumonia patient may injure another. Those who conduct the so-called 'practical journals,' and more particularly the readers of these journals who love so-called 'practical matter,' should note that more is required of the physician than a diagnosis of the disease by name only. If it were otherwise, doctors would not be necessary, for the majority of people can tell a case of whooping cough, of measles, of typhoid fever, and of other common diseases. The people would need merely to look in a book and see the treatment. The doctor is supposed to treat, not a name, but the individual patient and the particular conditions in that patient. There is no 'best treatment for diabetes,' but what is best for each patient must be settled first by determining the actual pathologic conditions in the individual affected.' "

"**Twilight Sleep**," as an obstetric procedure, was reintroduced in this country through the lay press in such a manner as to give it a commercial aspect. In fact, it was announced in a monthly magazine with every appearance of a paid for invitation to wealthy pregnant women to go to Freiburg for delivery. The article even stated that women delivered by the "twilight" method gave birth to healthier babies—that the children were *better looking*, grew faster and were stronger. This nonsense in itself branded the whole article as an advertisement of the Freiburg hospital.

Were it not for the dangerous character of the "twilight" treatment, especially when attempted by a physician neither fully in-

structed nor aided by competent assistants, it might fail to interest the general practitioner, but the trouble is likely to come from physicians who are not properly prepared for the work yielding to the demands of their pregnant patients.

The unprofessional manner in which the German hospital allowed (or caused) its work to be announced in this country no doubt delayed investigation by our physicians, but the subject has recently received considerable attention from some of the most prominent American obstetricians, as is shown by a series of articles published in the December issue of the *Medical Times*.

Dr. J. B. De Lee, professor of obstetrics in the Northwestern University, Chicago, in giving his experience with the "twilight sleep," says:

"The drugs used in producing the twilight sleep carry inherent dangers which have not been completely eliminated, even in Freiburg. The general re-employment of the method—discarded ten years ago and again seven years ago—will result in the repetition of the bad experience of those times. Practiced by specialistically trained obstetricians, in a specially equipped maternity hospital, with an abundance of trained assistants and nurses, the dangers to mother and child may be reduced to bring them to a point where one may well consider the advantages and disadvantages to more nearly balance each other. Even under these circumstances one will have to reckon with a certain toll of infants' deaths and injured mothers. For general use—especially in the home—the drugs are contra-indicated."

Dr. J. C. Applegate, professor of obstetrics in the Temple University, Philadelphia, in referring to his former use of the Freiburg treatment, in part says:

"From my personal experience with scopolamin-morphin anesthesia in obstetrics in 1906, when it was being used quite extensively in our hospitals as the anesthetic in general surgery, and again quite recently, I am forced to the conclusion that this treatment has a very limited place in obstetrics. In 1906 it was used routinely as the anesthetic in a series of cases, but finally almost wholly abandoned because of the unpleasant effects and after-effects —mental and otherwise—on the mother or baby or both in about 75 per cent. of the cases. Since then and until recently, its use has been limited largely to the one dose, preliminary to some other anesthetic in operative obstetrics. Since the widespread notoriety given to the method, and because some expectant mothers want it, we have again been prompted to adopt it, by way of experimentation, and observe what was originally observed, viz.: That the results were very satisfactory in a small percentage of cases, with whom the labor was progressively active, when both the involun-

tary and voluntary forces were vigorous and little or no resistance existed to interfere with the normal termination of the labor. The one dose—morphin 1/6 and scopolamin 1/100—is also valuable in dystocia, given preliminary to the administration of ether or chloroform, when the labor is soon to be terminated by instruments or section, under which circumstances the amount of ether or chloroform may be reduced one-half."

Dr. J. W. Bovee, professor of obstetrics in the George Washington University, Washington, D. C., well points out the necessity of confining the "twilight" treatment to obstetrical experts, and in part remarks:

"It has a place in obstetrics, though a very limited one. It should be used only by those who are expert first in obstetric practice and second in the physiological action of the powerful drugs employed, especially when administered to women in labor.

"It demands careful, continuous and tedious observation on the part of the obstetrician and an isolation of the patient and attendants away from family, which latter, from the standpoint of obstetrical cleanliness, might always be advantageous. I believe, too, it endangers the welfare of the infants."

Chronic Headaches, in which the cause cannot be found and satisfactorily explained, should be carefully examined as to refraction and ocular balance. This should never be neglected.

FYFE.

Report of Meeting of Committee of the Board of Regents on Proposed Legislation.

The Regents Committee consisted of Vice-Chancellor Sexton, Dr. Vandeveer and Regent Adelbert Moot. There were present the members of the Council, the State Board of Medical Examiners and representatives from the State Eclectic Medical Society and the New York State Medical Society, the Osteopaths and the Dean of the Homeopathic Medical College. The first topic discussed was that students be admitted to the study of medicine conditioned in Chemistry, Physiology and Biology. It was recommended that Biology and Physiology should be allowed to be regarded as suitable subjects for condition. A division of sentiment was held in regard to Chemistry and some recommended that condition in this subject be permitted, by others that one year in chemistry should be required.

The second topic: An addition to the authority of the Regents to be passed by the Legislature authorizing the Board of Regents to enact changes in its rules regulating the requirements and standards regarding the preliminary requirements of students and the extent of the medical course and its character in the colleges and that these be governed by the rules of the Regents so that they can

be changed from time to time without the necessity of legislative enactment. Sentiment upon this recommendation was divided, a majority of those present being in favor of the proposition, a minority nearly as great in number against such an arrangement.

The third topic: "Unprofessional conduct" means and shall include the following acts or conduct by or on the part of a practitioner of medicine:

(a) Advertising fraudulently either in his own name or in the name of another person, firm, association or corporation in any newspaper, pamphlet, or other printed paper or document, or by writing letters or causing them to be written, wherein or whereby the medical practitioner holds himself or herself out to cure diseases or defects or for being employed by any person, firm or association or corporation so advertising or announcing.

(b) Wilfully betraying a professional secret.

(c) Habitual drunkenness or addiction to drugs.

(d) The employment of any capper, solicitor, or drummer for securing patients, or the division of fees or promise of division of fees or the payment of money to any person or persons, or of any other valuable thing in return for service in securing patients.

An addition to the law that revocation of license be authorized by the Regents of a practitioner declared insane or confined in a State hospital for the insane. A vote being taken the amendment was favorably recommended.

The chairman of the committee announced that in consideration of the requests of some of the representatives present for further allowance of time be given for more thorough consideration of the proposed changes that no definite action would be taken until a special meeting of the Regents to be held early in January. In the meantime the committee would be pleased to consider any memoranda which might be submitted for the improvement of the recommendation as above outlined, so that they might fairly represent the opinions of the medical profession.

Original Articles

Duodenal Ulcer—Its Diagnosis and Treatment With Report of a Case.

BY EARL H. KING, M.D.

Read before the Saratoga Springs Medical Society, March 28, 1914.

In presenting this subject to this society tonight I am moved to call your attention most decidedly to the frequent and apparently increasing existence of various forms of so-called chronic indiges-

tion, with the tendency to acute exacerbations, and along with this the resort by so many of the laity to the widely advertised proprietary medicines for the relief of the distress incident to the above symptom (for the term 'indigestion' as usually used really is.)

We find patients floating from one medical man to another for treatment for these conditions and during the intermissions between such consultations trying all the recommendations of friends, and the glowing reports of cures by nostrums cause these sufferers to be ever adding to the profits of the nostrum venders. Perhaps no class of remedies enjoy such sale as those prepared for the relief of "stomach, intestinal and liver disorders."

Why is this and why are we often unable to give our patients more than temporary relief and then he seeks someone else or tries some or all of the many pathies that cater to chronic cases? I venture to say that the medical profession is often at fault for this condition of affairs, not only in this class of cases, but also in other diseases ammenable to treatment and perhaps cure. I say at fault, for how many are in the habit of simply prescribing a stomach tonic, a digestive and caution as to diet—the latter too often not heeded—and usher the patient out without digging down to the fundamental cause of the digestive symptoms which are many times deep seated and of long standing, but may be in the incipiency or entirely reflex in the stomach from causes remote from it.

This is not said with the intention of sermonizing, but rather with the idea in view of urging the more thorough study of all chronic conditions or incipient ones before they become chronic. There is no reason why so many should be going to the larger cities to consult men following special branches if every man would endeavor to make a complete and thorough diagnosis of his cases. We all have at our disposal the modern methods of accomplishing this end and do we not often neglect to make use of them.

It is well known that there are four or five conditions which underlie these digestive derangements, namely—gastric ulcer, duodenal ulcer, chronic appendicitis, gall bladder troubles, and chronic constipation (which latter may be due to some organic disease or deflection of the intestinal tract.)

Indiscretion in eating and drinking is perhaps responsible for many of these symptoms, but it is also many times the cause of the more serious underlying disease. Then again the frequency with which malignancy is the sequlae of some of the above mentioned diseases, if not relieved, should be sufficient reason for a thorough study of all cases presenting themselves to ascertain whether we have a simple or some deep seated and perhaps serious trouble to deal with.

With this end in view I beg to bring before you a brief study

of duodenal ulcer which is perhaps of more frequent occurance than is generally believed.

Etiology: There are many cases of duodenal ulcer as well as gastric in which the cause is not determinable, but both present similar etiological factors; namely, conditions producing hyperchlohydria and the resulting erosion by the irritating gastric juice. When we remember that acid gastric contents pass into the alkaline medium in the duodenum and are there neutralized and finally made alkaline it is evident that the more acid the former the more difficult and prolonged the accomplishment of the latter with the consequent irritation. The hyperacidity is so often due to indescretions in diet and the stimulation of gastric secretions by highly seasoned foods and the injuditious use of alcoholic beverages.

Burns of the abdomen, feezing, erysipelas and septicemia are among the etilogical factors. These conditions producing a lowered vitality predispose the mucous membrane to irritation from gastric juice. Direct local infection from acute infections elsewhere in the system seems also to be a plausible argument.

Pathology: The result, regardless of the cause, however, is the same—a punched out funnel shaped ulcer, usually single, though sometimes multiple or accompanied by gastric ulcer, extending down through the submucousa and muscular layer, and still more frequently than when in the stomach perforating, with the result of producing either adhesions to adjacent viscera or general peritonitis. Duodenal ulcer when it heals is likely to produce more serious results from scar formation than when situated in any part of the stomach, other than the pylorus, because the duodenum is of so much smaller calibre that obstruction of the lumen more certainly follows cicatricial contraction. This emphasises the possible continued gastric disturbances from motor causes even if the classical course of ulcer as formerly taught did not go on to hemorrhage, perforation and resulting infection of adjacent structures. With modern means of determining its course we are led to believe that many of the ulcers heal with resulting cicatriziation and more or less obstruction to the outlet of the stomach.

This resulting obstruction would seem to suggest the reason for so many dilated stomachs that are diagnosed and reported in literature as well as the many cases of so-called fermentative dyspepsia and numerous cases in which gaseous eructation is a prominent symptom, many of these conditions existing seemingly regardless of the form of diet.

This leads to the belief that duodenal ulcer or ulcer of the very proximal end of the pylorus is of more frequent occurance than is generally supposed. The classical symptoms are not always present, the ulcer having been of a simple type and having healed leaving a

cicatricial mechanical obstruction with the above mentioned resulting pathology.

Peptic or round ulcer of the duodenum is less frequent than gastric ulcer and is still more likely than the former to run a latent course until hemorrhage or even perforation and its sequences call attention to it. The general consensus of opinion seems to be that duodenal ulcer occurs about the proportion of one to ten of gastric ulcer, but as has been suggested with more improved methods of diagnosis and a careful study of these cases, it would seem that it is more frequent than this. Mayo recently states that it occurs in the proportion of one to three or four.

It occurs more frequently in men than in women and between the ages of 20 and 60 years. It not only tends to run a more latent course than gastric ulcer, but also is more refractory to treatment and has a greater tendency to perforate, and as has been outlined above to cause obstruction, and is in consequence of these tendencies a more dangerous disease. It may occur in infancy while gastric ulcer is seldom seen before the age of ten years.

Its site is most frequent at the upper end of the duodenum between the pylorus and the common bile duct. Generally it is quite close to the pylorus, though it sometimes appears lower down, and exceptionally may be found in any part of the duodenum, or even in the upper part of the jejunum. It varies in size from that of a pea to that of a twenty-five cent piece, or even larger in exceptional cases.

Symptoms: In this connection will be considered also the pathological findings in the blood, stomach contents and stools which of course in addition to constituting the pathology of the disease are prominent symptoms in diagnosis.

Clinically there may be nothing of note until hemorrhage suddenly occurs which may be more or less severe, but by careful investigation it will very frequently be found that the patient has suffered more or less from so-called indigestion or discomfort sometime after eating which has not been of sufficient note to cause him to seek medical aid or else he has been using cathartics or digestives on his own initiative for its relief.

The symptoms may be similar to gastric ulcer, namely burning or boring pain with circumscribed tender spots.

The symptoms when present are a burning, boring pain in the epigastrium to the right of the median line about two fingers breadths below the free border of the ribs, and may radiate upward or downward and not usually through to the back. This pain and discomfort does not usually occur immediately after taking food, but rather some two to four hours afterward, and sometimes even six hours; that is, until the contents of the stomach at the termination

of peptic digestion have all passed into the doudenum. This pain is not increased by taking food or alcholic drinks as in gastric ulcer, but is more apt to be relieved by them. There is tenderness, usually on pressure almost uniformly felt to the right of the median line near the lower border of the liver or a little lower down in the right hypochondrium. However, the site of the ulcer being near the pylorus and the latter not infrequently being displaced downward the location of the tenderness may be displaced accordingly.

The above symptoms are contrasted with gastric ulcer; in the case of the latter the pain usually occurs immediately or soon after taking food and is aggravated by additional food, and the location of the pain is usually to the left of the median line with the tenderness directly over the epigastrium and extending through to the back with tender spots over the attachment of the last two ribs.

Hemorrhage when it occurs in duodenal ulcer, if it is vomited, there is also some appears more or less simultaneously in the stool, either fresh or slightly changed or in the form of melena. In contrast to this with gastric ulcer the blood is all vomited and none appears in the stool. It may be, however, and frequently it is so, that blood appears in the stool and is never vomited. In fact blood in the stool may not appear on macroscopical examination and yet under the microscope it is found to be present. Some authors hold that blood is always present in the stool in doudenal ulcer even if it be in only minute quantities.

Another feature of the hemorrhage in these cases is that when hematemesis occurs the vomitus will, at first, consist of nothing but food remains or chyme and then later the blood will come up possibly mixed with bile; while in gastric ulcer the blood is likely to come up all at once with the food just taken. This is an important diagnostic point. The hemorrhage may be moderate and recurrent or may be sufficient to cause collapse or sudden death.

Those cases which have existed without prominent clinical symptoms are the ones most likely to experience sudden and severe hemorrhage while those that have had long continued symptoms with occasional signs of blood are less apt to have severe bleeding. Occasional tarry stools following the characteristic pain and distress is quite if not prominently suggestive of duodenal ulcer.

The examination of the test meal in duodenal ulcer is not as helpful as in gastric ulcer. In the latter hyperchlohydria is characteristic while with the former it may exist or there may be hypochlohydria. It is quite possible that when there is an excess of free hydrochloric acid in the case of duodenal ulcer there may be co-existing pyloric ulcer. Mayo points out that the laboratory findings as regards the free acid in the stomach contents in cases of duodenal ulcer is not reliable.

The blood: This is extremely variable and it is not always evident

what conclusions to draw from the examination. Some cases appear to have suffered no permanent change in the composition of the blood but from their anemic appearance it is probable that the total volume of the blood has been reduced without marked alteration in its quality.

The usual state of the blood, however, is one of marked secondary chlorotic anemia, with little or no leucocytosis. While the degeneration of the blood after hemorrhage is often very rapid it seldom is complete and there seems to be some influence, possibly found in the diminished digestive power in the stomach, which causes the anemia to persist.

Where severe hemorrhage has taken place the blood furnishes a marked example of post-hemorrhagic anemia. Those who survive this ordeal show as low as 1,000,000 R.B.C. with low Hb. index. Cases in which no marked hemorrhage has taken place, but the R.B.C. is down to 3,000,000 have usually suffered from slow bleeding or hemorrhages which have passed unnoticed. Grawitz reports one case with R.B.C. 400,000.

Leucocytosis of moderate grade is usually present especially if hemorrhage has taken place. In quiesent cases with rectal feeding there is usually a slight leucopenia, but the resumption of stomach feeding will usually excite a leucocytosis, Cabot reporting a case in which the first stomach meal raised the white blood count from 4,000 to 15,000.

Constipation may exist in those cases, but not sufficiently frequent to be characteristic. Jaundice is rare, but when it does occur it is very significant as to the location of the ulcer.

Boas has pointed out that it is sometimes difficult clinically to diagnose between duodenal ulcer and hyperchlohydria per se. The pain in both occuring two to four hours after a meal and he states that only by treatment with rest in bed and rectal feeding can a differentiation be made. In case the patient does not improve with the treatment and diet for hyperchlohydria he then suggests the treatment of duodenal ulcer.

Duodenal ulcer must also be differentiated from tabetic crises, gall stones, and cancer. In tabes the pain has no relation with taking of food, there is no tenderness and other characteristic symptoms are usually present. The attacks of gall stone colic and its occurance regardless of food present with the possible jaundice and other characteristics of its course should not be difficult to discern.

As has been suggested above, however, there are many times that a differentiation cannot be made clinically, but with the advent of Roentgenology and the improved recent technique in the examination of the stomach and intestines we have a method that is approaching infalibility in the examination and diagnosis of maladies of these viscera.

The late Dr. Leonard in the *American Journal of Roentgenology* said: "The surgeon today does not attempt an operation on the stomach until he has before him all the data which this method is capable of rendering, while the internist does not refer his patient for operation before the knowledge it affords shows that operation is necessary. In many instances the complete knowledge of the condition of the stomach and intestine can be obtained by this method of examination as by an exploratory laparotomy, while the definite knowledge it affords localizes operative intervention and eliminates its extent and nature before it is commenced."

It has been found that ulcers of both the stomach and duodenum that have passed unnoticed and unsuspected have shown up in Roentgenological examinations with subsequent proof of their existence.

Little has been known of the normal or pathological action of the duodenum from a mechanical standpoint until its study Roentgenologically. As you well know this study is accomplished by the visualization of the digestive organs by the ingestion as well as by enema of a large quantity of Bismuth salt or some other substance of like nature, notably Barium Sulphate, the technique of which is important, but which is not necessary to detail here.

The passage of the Bismuth meal, in normal cases, through the small intestine is so rapid that the determination of its normal peristaltic action is attended with great difficulty. With the exception of a small mass in the bulbus duodeni and the collection of masses in the convuloted portions of the ileum, little is seen in normal cases. The rapid roentgenogram shows in addition small flecks of bismuth scattered throughout the duodenum, the jejunum, and upper portion of the ileum.

The first portion of the duodenum, or the bulbus duodeni, retains the Bismuth because of its different anatomical structure. Instead of the valvulae conniventies, such as are found in the other portions of the duodenum, it is perfectly smooth inside with many secretory glands distributed over its surface. It differs also in its external support being held in place by a separate fold of the gastro-hepatic ligament. The second or descending portion is bound tightly down by the parietal peritoneum and thus has no messenteric attachment. Physiologically the bulbus duodeni, which has been called the second stomach, is of great importance, as it receives the acid chyme from the stomach and neutralizes it before it passes through the rest of the intestine. It also acts as a buffer to receive the food ejected from the stomach. Because of the acid chyme it receives it is more liable to be the seat of ulceration.

The study of cases roentgenologically has shown that the doudenum in its peristalsis both mixing and progressive movements. The third or ascending limb of the duodenum passes upward and back of the stomach to form an acute angle where it unites with the

jejunum. The bismuth meal passes through, or rather each bolus of it ejected from the stomach passes through the entire duodenum in from twenty-five to sixty seconds in normal cases. A series of instantaneous radiograms taken rapidly during this period shows the entire cycle.

Many pathological conditions of the duodenum can be observed and recorded in this way, but the existence of ulcer is the one before us.

In superficial ulcer of this part of the intestine the emptying time of the stomach is normal or increased, in contrast to the delayed emptying in cases of gastric ulcer, which produces a spasm of the pylorus. The stomach generally has the hypertonic form, the pylorus and greater curvature lying above the umbilicus. The stomach is not dilated at its lower pole, as in gastric or pyloric ulcer. The peristalsis of the sinus is more marked and the pylorus opens more frequently. The points of tenderness on pressure is located over the bulbus duodeni and the patient if asked to locate the pain usually places the finger over this spot.

A number of cases have been reported in which gastric and duodenal ulcers have been found to co-exist. Here a conflict in symptoms has been noted, the duodenal ulcer counteracting the spasm of the pylorus provoked by the gastric ulcer, resulting in more rapid evacuation of the stomach than normal.

Penetrating ulcer of the duodenum is less frequent and has in addition to the symptoms of superficial ulcer the characteristic diverticulum outside the normal shadow of the duodenum which persists as a small fleck of bismuth after the duodenum is empty.

A condition characteristic of ulcers of the duodenum is the retention of the opaque chyme in it for a longer period than normal as the result of a mild stenosis, possibly spasmodic, at the duodenojejunal juncture. It is probably that many of the so-called Lanes kinks situated at this juncture are in reality spasmodic stenoses due to duodenal ulcer rather than to actual kinks due to ptoses. This is more likely because of the defective mode of examining these patients which errs in making the examination in the right lateral position rather than in the upright, in which position the nature of the kink it would be most marked and more easily observed. In addition, after the administration of the opaque meal, the patient was placed upon the right side, thus causing the filling of the duodenum and aiding the retention of the bismuth in the organ.

Spasms of the duodenum due to neuroses produce transient symptoms that are characteristic of ulcer of mild stenosis but can be differentiated by their amenability to appropriate treatment.

Stenosis of the duodenum is characterized by the abnormal repletion and the presence of visible peristalsis and antiperistalsis. The dilatation of the duodenum is greater the narrower the stenosis

and the extent involved longer according to the situation of the stenosis. The peristalsis is uninterrupted so long as the opaque chyme is there retained. The character of the stenosis, whether it is spasmodic, cicatricial, due to pressure bands from without or the result of new growths, cannot always be determined by the Roentgen method.

In the diagnosis of this condition, Roentgenologically, account must be taken of the possible stage of the disease. That is whether we have an active ulcer present or whether there is partial or total healing with cicatricial contraction. For example, Barclay, X-Ray Director of the Manchester Royal Infirmary, England, in his recent work on this subject gives the following symptom complex form the Roentgenological point of view:

(1) The stomach always exhibits good tone, even if ptosis is present.

(2) The peristalsis is more active than normal, especially when the food has commenced to pass through the duodenum.

(3) The food begins to leave the stomach almost at once and as a rule continues to pass out very rapidly until the stomach is empty.

(4) The pyloric relaxation is so complete that large masses of food are seen passing through the duodenum instead of the fine almost imperceptable stream that can only be detected with certainty by means of an instantaneous roentgenogram. In certain cases a separate bolus is seen remaining apparently in a pocket in the duodenum.

This picture is characteristic of an active disease, but with healing more or less complete with the resulting cicatricial contraction this picture changes to one of partial or complete stenosis with retention of food in the stomach and possible dilation.

The tendency toward a development of malignancy on the site of a healed duodenal ulcer does not seem to be so great as in peptic ulcer, yet such does occur.

A diagnosis having been certainly made of this condition the question immediately arises what course of treatment shall be pursued.

In simple cases undoubtedly medicinal treatment should be adopted as the first resort. Absolute rest of the diseased organs seems to be the rational procedure with rectal alimentation with perhaps plenty of water by mouth and sufficient alkalies to neutralize the acidity of the gastric juice and thereby prevent as far as possible its irritating tendency on the lining of the duodenum. The use of bismuth in moderately large quantities may be of some benefit, but does not show in practice as marked benefit as in gastric ulcer. It is a notable fact that has been frequently observed in the

roentgenological study of the stomach and small intestine that following the ingestion of the bismuth, and continuing for sometimes several days, a relief to a more or less degree from the distressing symptoms. This relief seems to disappear in direct proportion to the rapidity with which the bismuth is carried away from the crater of the ulcer.

No doubt the diet or rather the absence of it for several hours during the series examination is also a factor in giving relief.

Rest in bed is of great importance if medicinal treatment is employed.

The use of Hydrastis (non-alcoholic) in ten to fifteen drop doses every two to three hours aids in the healing process. The following prescription meets the above suggested treatment very nicely both in this condition and also peptic ulcer cases:

Pulv. Hydrastis, ℥i.; Magnesiae Calcined, ℥v.; Bismuth Sub-Nitrate, ℥v. M., et. ft. Chart. No. . Sig. One mixed with water every two or three hours.

If there is much fermentation with the formation of gas, add to the above one and one-half drams of Bismuth Beta-Napthol.

When diet by the stomach is commenced give milk and cream, an ounce of each, with lime water, every hour or two, and as the symptoms improve custards, rice (well cooked), cream of wheat, raw or soft eggs, baked potato, malted milk, avoiding anything that is acid or anything containing alcohol.

If the bowels are sluggish enemas with the use of castor oil or some good preparation of the Russian Petroleum oil internally will be the least irritating and effective.

Should a symptomatic cure result from such course it should be made reasonably certain later that the healing has not resulted in sufficient cicatricial contraction as to embarrass the proper emptying of the stomach, with the secondary condition resulting that has already been outlined. This might not be apparent clinically until sometime afterward, but a careful roentgenological study of the apparently cured case would clear this matter up.

Some cases have been reported where healing with considerable cicatrix formation has taken place where the use of thiosinamin internally over a considerable period has seemed to soften the cicatrix and restore an apparently normally patulent duodenum. This, however, is doubted by some of the best authorities. Personally I have had no experience with it.

The general consensus of opinion seems to be that duodenal ulcer is per se a surgical condition and should be so dealt with. Even if healing takes place there is a great proneness to recurrence.

If a simple ulcer exists and it is of small size, so that its excision would not embarrass the lumen of the intestine, that is the

operation of choice. If it be a perforating ulcer with perhaps adhesions to the neighboring organs more radical procedure is necessary. In cases where sudden and severe hemorrhage has occurred an emergency operation is made necessary to stop the bleeding and save the patient's life. Even with slow bleeding, with more or less rapidly developing anemia, no time should be lost in proper surgical intervention for its relief.

Where it is of such magnitude that a considerable amount of the bowel must be sacrificed with perhaps total or complete closure of the pylorus, or where this has already taken place from cicatricial contraction provision must be made for the proper emptying of the stomach by some other route. There have been many methods employed and many ways suggested with varying results. Probably the most accepted method today is the posterior gastrojujenostomy according to the Mayo method. In short, this consists of an anastamosis of a loop of the jejunum, sufficiently near the duodenum to prevent a pocket or trap formation, to the posterior wall of the stomach, low down toward the pylorus, by passing the former through a rent made in the least vascular portion of the transverse mesocolon thereby forming a new exit from the stomach. At the same time the proximal end of the duodenum and the entrance of the bile and pancreatic ducts are preserved, these fluids passing down to the new gastro-enteric union and there mixing with the chyme to perform normal intestinal digestion. In some cases all that is necessary in treating the ulcer, if the above anastamosis is done, is to Lembert it over as a reinforcement and the relief of the function of the part allows healing to take place.

The anastamosis must be near the pylorus in order that the stoma may be as efficient as possible and the accumulation of residual chyme in the pocket formed below it prevented. Then to it has been proven that a high anstamosis does not perform the function intended as the stomach peristalsis forces the chyme toward the pylorus and not through the stoma. The exit from the stomach taking place where the pressure is the greatest.

The exact technique employed in performing this operation will not allow of elucidation here.

The mortality in this operation is less than two per cent., and with the patient not too much debilitated and in cases not too far advanced it should be almost nil.

As to the possibility of recurrence, Dr. W. J. Mayo notes that results following operation in 600 cases of gastric and duodenal ulcer, eighty-one per cent. were so relieved as to be considered cured and ten per cent. were markedly benefited: that is, that ninety-one per cent. were cured or improved and that five per cent. of the

remainder were moderately improved. The percentage refers entirely to the duodenal group. The gastric group did not show as good results by three or four per cent. He also says that recurrence is many times more apparent than real and that what appears to be recurrence is due to faulty suturing. Suture ulcer occurring rather than real recurrence. This can be minimized, according to Mayo, by using very fine silk or, better still, catgut for the inner row and fine silk for the outer row of sutures.

As an illustration of some of the points mentioned in this paper I beg to report a case with a presentation of the roentgenograms taken in making the diagnosis.

Patient, male, 35 years old, poorly nourished, weight 145 lbs., height 5 ft. 11 in., occupation accountant, presented himself to me during September, 1913, complaining of indigestion and distress some time after eating. A thorough study of the case was not made at that time and a stomachic and digestive were prescribed and repeated once or twice during the next three or four weeks following. He then discontinued treatment until early in December of the same year. The condition still remained about the same with perhaps some aggravation.

On December 18, 1913, the following history was recorded. Had typho-malaria while doing service in the Spanish-American war in 1898; now has recurrence of the chill every August. Mastoiditis in 1906, which was operated. Mother died of gastric cancer, family history otherwise negative. For six months past has had much gas in stomach, distress in stomach very noticeable appearing about three to five hours after a meal, this being more marked in direct proportion to the kind and amount of solid food ingested and less marked if a fluid or soft diet was indulged in. Pain designated as central above umbilicus extending to the right hypochondrium and to the back centralizing in the middle dorsal region. Pain sometimes relieved by the eructation of gas. Never any nausea or vomiting, but he experienced a peculiar "twitching" of the stomach, as he described it, with eructation of mucous and some particles of food all of which was tasteless.

Bowels irregular, inclined to constipation, stools dark brown, no tarry appearance or signs of melena, even sometimes being light yellow.

Appetite good, no loss of weight, his build being a family characteristic. Tongue clean, normal color, slightly furred. Liver dulness one inch below costal margin and extending to left costal arch. Spleen slightly enlarged. Some epigastric distention and slight tenderness over right epigastrium which was increased considerably on deep pressure. Tympanities moderate, most marked over area three inches in diameter just above umbilicus.

Roentgenological examination Jan. 4, 1914. This showed a slow filling of the stomach with hyperperistalsis resulting when filled; with a deformed duodenum and signs of an ulcer at the gastroduodenal juncture just below the pyloric opening and on the upper side of the gut. Also a retention of almost the entire bismuth meal in the stomach and duodenum at six hours. (I regret being unable to give reproductions of these plates herewith.)

Diagnosis: Duodenal ulcer with resulting obstruction at the pylorus and delayed gastric emptying.

The patient was advised of the condition and the possible sequelae and operation advised.

Operation Jan. 15, 1914. Preparation as usual for laparotomy with the addition of an alkaline gastric lavage the day previous and also the morning of the operation. Incision vertical at right of median line from one inch below costal arch downward a distance of four inches. Exploration showed ulcer in exact location as in roentgenogram. This was apparently not active, but there was considerable cicatricial contraction. The area involved in the ulcer was Lemberted over thoroguhly, and a posterior gastro-jujenostolmy performed according to the Mayo method using the Oshner suture technique in making the anastamosis.

The patient stood the operation well and had some slight nausea for 24 hours following and vomited a few particles of clotted blood. There was also present some hiccough. Protoclysis was given every four hours and nutrient enemas every four hours. After 48 hours hot sterilized water was allowed by mouth in quantities of one ounce every two hours and in 72 hours albumen water in small quantities was given. Flatus was expelled in 36 hours. After one week a liquid diet with a minimum of condiments was allowed, small qunatities being given frequently. On the 22nd a soft poached egg was allowed and agreed well; on the 23rd after another poached egg he had some distress, and vomited one pint of yellow fluid which was high acid and contained particles of the egg. Sat out of bed on the tenth day although the back rest had been allowed from the day following the operation (this for the purpose of facilitating drainage of the stomach). On the day that the patient first sat up the dressing was done and primary union had taken place. During this time the pulse and temperature had been normal and the bowels had been moved by enemas. On the twelfth day the patient had another vomiting attack preceded by distention with gas and distress. The vomitus was also highly acid, and this phenomena was accounted for from the probable intolerance of the intestine at the new point of entrance of the chyme to the acid content of the stomach. A powder was then given every three hours consisting of five grains each of Magnesium Carbonate and Sodium Barcarbonate following which there was no further distress or

vomiting. This seemed to prove the above theory as to the cause of the phenomena.

On the fourteenth day castor oil was given by mouth with good results. The patient left the hospital on the 31st of January, sixteen days following the operation, weighing 133 pounds or twelve pounds less than he did six weeks previous, his weight not having been recorded just previous to the operation.

Since his discharge he has gained seven pounds, is eating well of a carefully prescribed diet, is having no gastric symptoms, bowels are regular and stools of normal character except perhaps slightly dryer than usual and occasionally clay colored. He feels well and has returned to his usual vocation.

(At this date December, 1914, as this paper is going to the publisher, we wish to report that this patient has steadily gained in weight until he has reached his normal, is attending to business every day, and is enjoying the best of health.)

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Saratoga Springs, N. Y.

Helonias Dioica.

BY DR. JOHN CORNELIUS SWALM

Chamaeliurm Luteum Gray.

1. Helonias Dioica Prush.

2. False Unicorn.

3. A genus of North American plants. Of the lilly family (*Liliaceae.*)

4. *Part used* "Sayre" says the rhizome, I use the F.E. The rhizome is of a greenish-brown externally, closely annulate, about 25 mm. (1 in.) long, and 6 mm. (¼ in.) thick, beset on the lower side with numerous wiry rootlets; internally whitish, horny; bitter.

5. *Structure*—Transverse surface is of a dirty white hue and of a horny texture, and exhibits a well-defined central column, occupying about 1-3 the diameter.

It has been used as an adulterant for sanguinaria.

6. *Properties*—Tonic, Diuretic, Arithelmuritic.

7. *Habitative*—Is in low wet places, and is grown from Pennsylvania to Virginia.

The root is a positive stimulating uterine, and ovarine tonic, for all depressed conditions of these organs. And is useful in prolapsus uteri, also in uterine atony, relaxed vagina, barrenness or sterility, post-partem hemorrhage, menstrual excesses, and leucorrhea, or where there is a liability to miscarriage. Very few agents take its place.

Can you use any other single agent that will prevent miscarriages? even when the pains become very prominent and the hemorrhage has made its appearance. In this condition it is absolutely reliable, in the hands of your humble servant.

But I prefer not giving it to married ladies, who are frail weaklings, and those who are liable to very frequent pregnancies.

It can be given to tone the mm. throughout, as in gastric irritation or gastric torper.

It sooths and tones the membranes, promotes the appetite and assists the digestion; and frequently this agent is tolerated by the stomach when other agents are absolutely refused, and for this reason is valuable to ladies during pregnancy as a gastric and uterine tonic, because it stimulates the assimilative organs.

I consider it a stimulating diuretic of excellent value in cases of albumnuria and diabetes, with a genuine stimulating and toning effect upon the kidneys, bladder, uterus, and urethra, and is a fine agent in gleet.

Therefore it become a valuable agent in toning and supporting the generative and urinary organs of both sexes, and gives favorable results in enuresis.

Helonin—When given in 4 to 12 grs. doses, may be used to advantage in Brights disease; and its use is well marked in the treatment of dyspepsia, and the eradication of stomach worms.

Where there is a threatened miscarriage give F.E. (v to x mm.) in water every fifteen minutes to one hour as may be required.

If this agent is combined with aralia-racemosa and some other agent of similar influence its action on the bronchia as a fine stimulating expectorant and soothing tonic.

℞ Helonin; Viburnin, aa, 24; Dioscorein, 4; Avenin, 12; Caulo, 1.

This is a powerful uterine tonic.

Chicago, Ill.

Pruritus Ani, Scroti, and Vulva.

BY ALCINOUS B. JAMISON, M.D.

The early Greek, Roman and Biblical writers regarded hemorrhoids, or piles, as a disease; and no doubt anal fissure, abscess, fistula, pruritus ani, etc., were regarded by them also as separate and distinct diseases. Hence, through hereditary bent of mind and conduct, most subsequent writers on these subjects have accepted their premises and reaffirmed their conclusions, thus paying a compliment to the Greek and Roman physicians that they did not merit. But this illustrates the power of medical institutions to perpetuate error in diagnosis, and in makeshift treatment that is often barbarous and results in mutilating organs of the body beyond repair in an effort to remove a *symptom* of a disease—all due to ignorance of the pathological changes in the tissues invaded by chronic inflammation of the anus and rectum.

From the early history of afflicted mankind down to the present they have smote emerods, etc., without knowing the etiology or pathology of that symptom. There should be a law to prevent such surgical mutilators from giving exhibitions under the pretence of "scientific operations." As they were evidently ignorant of the origin or nature of the milder symptoms of proctitis, such as piles, fissure, abscess, fistula, etc., we could scarcely expect the hereditary surgical proctologists to know anything about the etiology or pathology of pruritus ani, scroti or vulva.

Early in the practice of my specialty I was able to make a clear and definite distinction between proctitis and its various local symptoms—also to make plain its grave effects on the whole system. Among the early pathological changes that result from chronic proctitis is the formation of mucus channels, sacs, spaces, etc., between the layers of the mucous membrane, as well as under the membrane itself—in the stratum of connective tissue in which so many blood-vessels are found.

The first pronounced change occuring in an organ under inflammation is an increase in the rapidity with which the blood circulates through the vessels—a so-called hyperemia—which soon gives place to a diminution (stasis) in the current, together with an exudation from the blood-vessels due to change in the structure of their walls. The exudation, which may be serous, fibrinous or albuminous, soon occasions a cloudiness of the connective and fatty tissues, and at the same time a desquamation (shedding in scales) of the epithelia (cells of the thin mucous surface) occurs. The inflammatory exudates destroy the normal connective and fatty tissues that surround and enter into the structure of the diseased organs; and as the destructive activity of the exudates takes place, hollow spaces, sacs and channels are formed in their progress through the

connective and fatty tissues that support the organs, as well as in regions further away.

These sacs, spaces and channels are primary symptoms of proctitis, and are revealed very soon after the onset of the malady, while pruritus ani, scroti, etc., are secondary symptoms. If the hollow spaces and channels are deep and pass just above the muscular tissue of the buttocks, the itching is not apt to occur (although odor and moisture may be observed), as the inflamed connective tissue along the channel does not disturb the skin; but when the spaces and channels are just under the integument, it also becomes inflamed, and itching usually results. Often, too, cicatricial tissue is formed in the integument and in the connective tissues along the course of the mucus channel. Sometimes the channels form a double subway in the buttocks—one channel running along the muscular tissue and the other just above it and near the skin, separated by newly-formed fibrous connective tissue.

If the onset of proctitis is quite active and continues so, and the sphincter muscles are in a somewhat relaxed state, the mucus channels formed under the layers of the mucous membrane and in the underlying connective tissue can easily pass under the integument about the anus and buttocks. The slight obstruction to the channels offered by the anal canal will prevent the formation of rectal sacs, ano-rectal sacs, and often muco-cutaneous sacs, commonly called internal and external piles by those having no conception of their origin or nature. Many of the channels pass from under the anal mucous membrane and integument and outside of the anal sphincters into the pelvic space around the rectum and sigmoid flexure and thence into more distant neighboring tissue, as well as in the connective tissue, both deep and shallow, of the buttocks and genito-urinary organs.

So numerous are the hollow spaces and channels in some cases that the pelvic space, the buttocks and the genito-urinary region remind one of a large sponge instead of the compact healthy tissues found in normal persons. The amount of exudates absorbed into the system from the large inflamed area is great enough to cause a peculiarly intense irritation of the nervous system, with more or less local and reflex pain throughout the body. Very often sufferers from proctitis and sigmoiditis and their varied symptoms are subjected to surgical operations on the appendix, ovaries, uterus, spine, etc., with the hope of removing the intense nervous condition of the sufferer. How long must mankind suffer from the ignorance of those that should know better?

During the first two or three years of my practice I did not know any more about the cause of pruritus ani, etc., than the authors of conventional text-books on the subject of anal and rectal

diseases, who usually devoted about fifteen pages to the "probable" cause of pruritus ani. Moreover, the entire subject-matter of the books I read and studied was of the same ancient imitative character of guessing referred to in the first paragraph of this article.

Having learned that proctitis is the cause of sacs, spaces and channels, and that these primary symptoms of proctitis often cause pruritus ani, a secondary symptom, the question of treatment and cure of the extremely annoying trouble is very simple, and often prevents the development of symptoms that are far worse than the tortures of the itching by day and night. As soon as one has obtained accurate knowledge of the pathology of the primary and secondary symptoms of proctitis, the question of where to cut through the skin to find the channels is also very simple. The anterior and posterior raphe usually show evidence of channels, whether itching is present or not. On either side of the anus are found muco-cutaneous sacs (so-called external piles), which are the outer evidence of a number of channels that pass into the tissue of the buttocks, as well as upward on the outside of the anal canal and rectum into the abundant spaces of fatty tissue that support the organs. Make an incision in the skin and connective tissue long and deep enough to expose a considerable area of channels, which should then be irrigated with antiseptic injections from a proper syringe until healed. Then another region should be opened, then another, and so on until the whole territory of channels is covered. At the same time, of course, proper attention should be given to the cause of the symptoms.

Proctitis and its severe local and general symptoms can be prevented by the examination of infants and children to see if the organs of elimination are in a healthy state. With healthy bowels and normal intestinal elimination of waste matter there will be little or no occasion for "diet" and medicine to "overcome" gastro-enteric disturbances.

43 West 45th Street, N. Y. City.

Items from the Field of Neurology.

BY THEODORE ADLERMAN, A.B., M.D.

Neuralgia of the sympathetic or of the vagus may occur in about the same manner as neuralgia of other nerves in the different parts of the body. In neuralgia of the vagus we mostly find that the pain is felt in the area of distribution of the sensory fibers of the affected nerve. The neuralgia condition may exist in either one of the gastric nerves, the vagi and in the splanchnias

The pain of intercostal neuralgia is often confused with the pain

which arises from the stomach. It is easy to diagnose if you remember that in intercostal neuralgia there are tender points in the corresponding intercostal spaces, about 1½ inches from the spine.

Do you know that ears, in many cases, produce head pains? The principal causes acting upon the ears to produce head pains are anaemia and mastoid disease.

The eyes will often produce the so-called ocular headaches. In these headaches the pain is as a rule very severe on using the eyes. Ocular headaches are found over the middle of the eyebrow and the pain seems to radiate into the back of the eyes.

If you examine the blood pressure in lead colic, you will find it increased from one-half to twice the normal pressure. This increased pressure seems to irritate the terminal nerve filaments and will often cause considerable pain by reducing the circulation in the intestine.

The periodic psychose as a rule offer fewer signs of grave disturbances of the lower functions of the nervous system than the majority of mental derangements, even in the very severe forms. The condition of the arteries is, however, of practical interest in these cases. In the melancholia stage of the circular form, for example, there is a vascular spasm with a weak, unsteady pulse. In the maniacal phase, the condition is reversed, the pulse is full and throbbing, the pressure great and the face flushed.

The Hebrews are very much predisposed to neurasthenia and neurasthenic psychoses. This may be explained perhaps by the intermarriage between consanguineous strains, by the urban, close, clannish life, which they have led for so many centuries. The Teutons are less affected, and the Russians still less. In this country the consegration of the population in towns, the existing mode, the rush of life, the continual struggle for existence, the peculiar vices, have all combined to produce the type of the nervous American—and the national disease of America—neurasthenia.

I forgot who it was that wrote the following verses:

"There is a pleasure in being mad
Which none but madmen know."

And this could be applied to many cases suffering from primary mania. They seem to overflow with a certain recklessness of conduct and the sense of well being and an overflow of spirit, which is so distinctly peculiar of these cases.

Tuberculous affections of the lungs are very rarely accompanied by actual psychoses, but still there are many instances in which, during the course of the disease, there developed a distinct hypochondriacal, melancholic and even an apathic disposion, or in some other cases undue exaltation and elation—but not enough to come to the degree of even a light mania.

Delirium is not an infrequent symptom in the last stages of chronic nephritis. It may be quiet or an active delirium, and is more of the sort which we know as the "low muttering delirium." The forms of actual psychoses which depend upon uremia vary with the nature of the renal trouble, and with the individual susceptibility of the case to the non-excreted toxins.

I have seen some cases of "mania transitoria," a delirious excitement, which may come on during the second or third day after childbirth, which arises suddenly and passes off as quickly. These cases should not be mistaken for the ordinary cases of puerperal mania which lasts for weeks and even months.

In some cases of paresis symptoms of exudative syphilis introduce the disease. The patient has at first palsies of the eyes, or attacks of hemiplegia with severe pains in head, followed by convulsions. The specific exudate is found to be pressing against the convexity or against the base.

I consider the "trifacial" one of the most important nerves from a neurological point of view, since diseases of this particular nerve produce more suffering and occur more frequently in neurotic individuals than in any other nerve. For the neurologist—the trifacial is a "good thing."

I heard so much about the great results obtained by some neurologists with quinine, in some cases of vertigo, that I fell to it. I tried it in a few cases, tried it in small doses, increasing till cinchonism resulted and had the pleasure of seeing it fail in each and every case. Hydrobromic acid in the form of a syrup, given in 30-drop doses, with salicylate of soda in 5-grain doses gave me some better results. I read a report somewhere, in which Hirt gave hypodermics of 10 drops of a two per cent. solution of pilocarpine with good results.

Hypochondriacal delusions relate to imaginary disease from which the patient thinks he suffers. He may be afraid to move less his bones will break. He may try not to laugh, less his face shall become paralyzed, etc., etc. As long as these beliefs do not interfere, well and good, but when they dominate the actions of the patient, they should be considered as evidence of insanity.

910 St. Johns Place, Brooklyn.

Materia Medica and Therapeutics

EDITED BY

JOHN WILLIAM FYFE, M. D.

Short Articles giving definite indications for remedies are solicited, and may be sent to DR. J. W. FYFE, Saugatuck, Conn.

Explosive.

The chlorate of potassium being a favorite remedy of many physicians of the Eclectic school it is of vital importance that we keep constantly in mind the fact that it must never be associated with any organic substance, as it is decomposed easily by a slight elevation of temperature, giving off its oxygen to the organic matter, and producing a dangerous explosion.

The above precaution is equally applicable to the permanganate of potassium.

Symposium on Treatment of Pneumonia.

Under the above caption several interesting articles on the treatment of pneumonia, written by practitioners of long experience, were published in the December issue of the *Medical World*. The articles were written by special request of the editor, and as they fairly well represent the three regular schools of medicine, no doubt the following abstracts from them will prove of interest to the readers of the REVIEW:

"I have found veratrin, or veratrum viride, not only effective in the initial stage, but also later on, when there have been signs of toxemia, with more or less delirium. In such instances the drug acts to favor greater elimination, with consequent riddance of the toxins. Other writers tell us that digitalis or digitalin should not be administered until the heart wavers, but it has been my observation that, administered with aconitin or veratrin, it overcomes the tendency to cardiac weakness. The use of strychnin is also decried by many, they insisting that no stimulation is required until there is a break in the

vitality. It has been my observation that this drug does well from the start. In small doses, far below the amount which would give any pronounced physiologic effect, strychnin seems to act as a synergist to other agents, in that it rather sustains the vitality of the patient and "splints" him, thus allowing no retrograde action to take place."—*Dr. G. L. Servoss* (old school).

"In the *early stages* you will find *aconite* a most valuable aid in assisting to overcome the acute inflammation, as indicated by the dry, hot skin, chilliness, great thirst, rapid pulse and high temperature. I give the 2 x (= 1/100) every fifteen minutes for 4 or 5 doses, then every hour while awake.

"*Veratrum viride* (green helebore) will suggest itself after aconite, where you find great *arterial excitement;* full, strong, incompressible pulse (or even slow pulse, indicating exhaustion).

"In this stage the heart is showing signs of the great stress laid upon it. This remedy is my *sheet* anchor in the early stages, and, in fact, I use it until I have positive evidence of the indication of something else. It is a great relief to use a drug that serves so faithfully and so well in a diseased condition that so taxes the skill and ability of the physician.

"Its action on the engorged lung and in sustaining the heart through a crisis so dreaded by all, avoids the necessity of using stimulants, such as strychnia and others which are so deadly in their reaction.

"*Bryonia* is the soverign remedy for all inflammation that has advanced to the *stage of effusion,* and acts powerfully upon the serous membranes and the viscera they contain. In pleuro-pneumonia it is almost a specific. The chief characteristic symptom is the stitching, tearing pains, greatly aggravated by motion of the inflamed membrane, which is relieved by rest. I give 3 x every hour."—*Dr. W. H. Shane* (homeopath).

"In the aged the vasorelaxants and constrictors so essential elsewhere descend to secondary place and occasional indications; while the pulmonary stimulants take first rank. In the front of remedies as to the relative frequency of indication I would place this group, of which sanguinaria, senega and squill are the principal members. They arouse the drooping powers of the lung, awaken sensation, and cause the bronchi to feel and throw off the encumbering collections. The nitrate of sanguinarin, in doses of 1/10 grain, every one, two or three hours, continued until the patient is coughing sufficiently, is a remedy whose value I can scarcely exaggerate. If it occasions vomiting, so much the better; it is not depressant, and nothing more effectually frees the bronchial tract of secretions. The effect on the system in

general is powerfully stimulant, and bowels and bladder are strengthened.

"I do not like digitalis with these cases. Its power of constricting the arterioles is so great that the danger of inducing gangrene by stopping the supply of nutrition is perilously increased. If the heart needs help, substitute spartein in full doses for the bloodroot. If pulmonary dropsy is present, with hydrostatic effusion or threatened edema, employ squill. Frequent change of position prevents that interference with the nutritive circulation that forms one of the main dangers of this condition."—*Dr. W. H. Waugh* (old school).

"For obvious reasons all diseases should be correctly diagnosed in accordance with the present nosologic classifications, but such diagnosis should not materially influence the treatment of a patient. He should be treated according to the specific indication for the needed drugs, regardless of the name of the disease from which he is suffering. In other words, the patient, not the disease, should be treated.

"In my practise I have found one or more of the following remedies always required in the treatment of the pathologic states usually manifested in pneumonia:

"*Aconite* when the heart's action is rapid, the pulse small but hard and wiry. *Asclepias* when there is a tight, hard cough, sharp pain and the heart lacks tone. *Baptisia* when the tissues are full and dusky and the tongue is full and purplish. *Belladonna* when there is capillary congestion. *Bryonia* when the pulse is hard and vibratil, or when there are sharp, lancinating pains and harassing cough. *Echinacea* when the tongue is full and of a dusky hue, and the tissues are of the same color. *Ipecac* in minute doses when there is irritation of the mucous surfaces. *Jaborandi* when there is high fever and the skin is hot and dry. *Nux vomica* when the tongue is full and pale. *Podophyllin* when the tongue is broad and full and covered with a dirty-yellow coating. *Quinin* when periodicity is a marked feature, providing the tongue is moist. *Rhus toxicodendron* when there is irritation of the cerebro-spinal centers as shown by a sharp stroke of the pulse. *Sanguinaria* when there is a tickling sensation in the throat causing almost constant coughing. *Sticta pulmonaria* when there is a hard, racking cough and pain in the occiput. *Veratrum* viride when the pulse is free, full and bounding. *Cactus,* as a means of sustaining the heart, should be employed in small doses from the beginning to the end of all cases of pneumonia.

"The above-named remedies, if employed in small doses in accordance with the foregoing indications, will cure a very large percentage of all cases of pneumonia. In addition to internal medication I usually have the compound powder of *lobelia* applied on a larded cloth to the chest. This application should be renewed every day."—*Dr. J. W. Fyfe* (Eclectic).

Spigelia—Pinkroot.

This plant is also known as Spigelia Marilandica, and is found growing in many section of the United States. It is said to have derived its name from Spigelius, a Flemish botanist and physician, who discovered its medicinal properties. Spigelia is extensively employed as a means of expelling worms, especially the ascarides variety, from the human body. When used for this purpose the required dose, which need not be large, should be repeated night and morning for two days, and followed by a cathartic on the third day, to prevent any narsotic effect which might result from absorption of the drug.

It is not, however, as a remedy for worms that Spigelia is most highly valued, but as a frequently needed medicament in abnormal states of the heart, as well as in wrongs of the nervous system. In endocarditis it is employed with much benefit, and in all neuralgic affections of the heart it exerts a relieving influence. It will frequently relieve, and many times cure, choreic tachycardia, and in functional palpitation it is a remedy of decided merit.

"Spigelia, in small doses, is a nerve sedative; in large doses a narcotic and anthelmintic. It is valuable as a remedy in functional diseases of the heart to quiet the nervous disturbance. It may be employed with certainty in the treatment of painful conditions resulting from depressed vitality, as in many forms of neuralgia due to loss of nerve energy in exhausted states of the system."—*Stephens.*

Spigelia is anthelmintic, carthartic, narcotic and sedative.

Indications.—Choreic tachycardia; nervous depression and irritability; burning, throbbing tensive pain in left side of face; occipital headache spreading to left side of the head; violent pulsating pain in left temple; reflex neuroses; functional diseases of the heart.

Dose.—Fluid extract, 10 to 60 drops; specific medicine 10 to 60 drops.

Usual Prescription.—℞ Spigelia, gtt. x to xxx; water, ℥iv. M. Sig. Dose one teaspoonful every hour to every four hours.

Ambrosia—Ragweed.

This indigenous plant yields a medicament of limited, but frequently valuable activity. It is usually prepared from the fresh flowers.

Ambrosia is employed as a general tonic, with good results, and as such is especially indicated in intermittent and remittent fevers. In dysentery and diarrhea it exerts a corrective influence, and in hemorrhoids it is deemed a remedy of value. Ambrosia is also recommended as a local application in sprains and bruises.

Ambrosia is astringent, tonic, stimulant and antiseptic.

Indications.—Hay fever; sneezing with excessive irritaton of the nasal passages; mucous fluxes.

Dose.—Fluid extract, 5 to 30 drops; specific medicine, 5 to 30 drops.

Usual Dose.—5 to 10 drops in a little water every one to four hours.

Society Meetings

The National Eclectic Medical Association.

The dates for the meeting of the National have now been definitely settled, Monday to Thursday inclusive, June 14-17, 1915. Headquarters will be at the Hotel Lankershim, San Francisco. Rooms on the European plan, $3.50 per day for either one or two in a room, $4.00 per day for room with bath with either one or two in a room.

The meetings will be held in one of the Fair auditoriums. Friday, June 18th will be known at the Fair as "Eclectic Medical Day."

We have recently learned that the round trip rates will be slightly lower than those mentioned in the December quarterly. The rates are as follows. Round trip from Cincinnati, $70.25; Pittsburg, $81.25; Columbus, $74.18; Indianapolis, $67.10; Cleveland, $76.20. Further details of the itinerary over the Pennsylvania from the east and from St. Louis or Chicago over the Burlington route, and the Denver and Rio Grande from Denver, with the various stopovers, will be announced later in the March issue of the *National Quarterly* and the February Journals.

New Jersey State Eclectic Medical Society.

An adjourned meeting of the New Jersey State Eclectic Medical Society met persuant to appointment, at 100 Halsey Street, Newark, N. J. at 8.30 P. M., Nov. 17, 1914.

In the absence of the President the Secretary called the meeting to order and on motion Dr. T. D. Adlerman was requested to act as Chairman pro tem.

The minutes of the last meeting were read and approved.

The Secretary read a letter from ex-President D. P. Borden of Paterson, expressing regrets for his absence.

There being no committees to report at this adjourned meeting and no applications for membership, the certificates of the Society issued at the last meeting were ready and presented to the following new members:

Dr. Arcangelo Liva, 328 Valley Brook Ave., Lyndhurst, N. J.
Dr. Chas. J. Massinger, Butler, N. J.
Dr. Samuel Messinger, 540 Orient Ave., Jersey City, N. J.
Dr. John J. Mohrbacher, 401 Bergen St., Newark, N. J.
Dr. Martin Nemirow, 171 Columbia Ave., Passaic, N. J.
Dr. David P. Russell, 709 Bergen Ave., Jersey City, N. J.

The recipients are all young men and enthusiastic and zealous of Eclecticism.

Death having removed our late President George Curson Young of Washington, N. J., the society on motion proceeded to elect a new president.

On motion Dr. G. E. Potter was placed in nomination. The doctor was honored by a standing vote of acclamation and elected president.

On motion Dr. Chas. J. Massinger of Butler, N. J., was elected Vice-President, Dr. Arcangelo Liva, of Lyndhurst, N. J., Secretary; Dr. John J. Mohrbacher, of Newark, N. J., Treasurer, for ensuing year.

The hour being late the incoming President was not prevailed upon for a speech.

Reading of papers also was held over until the annual meeting to be held in May, 1915, the exact location and date to be announced later on.

On motion adjourned to meet in May, 1915 at call of President.

Respectfully,
G. E. Potter, M. D., President.
Arcangelo Liva, M. D., Secretary.

Selections

Dysmenorrhea.

Thomas George Stevens, M.R.C.P., London, in his text book on "Diseases of Women," states, "when menstrual pain is sufficiently severe to interfere with a woman's' work or pleasure, even for a short time, it must be dignified by the title "Dysmenorrhea," and warrants treatment."

In the treatment of Dysmenorrhea, particularly the spasmodic type, H.V.C. has proven of especial service. It exercises an antispasmodic influence and is a sedative without being a narcotic.

Hayden's Viburnum Compound is a product of known composition, and when administered in teaspoonful doses, given in hot water, satisfactory results should be manifested.

The prevalency of Dysmenorrhea, and in consideration of the number of women who now earn their living, it is clear how important

it must be that they should not be incapacitated for even a few hours during each month, and Hayden's Viburnum Compound, properly administered in conditions where indicated, will afford relief.

The New York Pharmaceutical Co., Bedford Springs, Bedford, Mass., will send samples for clinical demonstration upon request.

Extracts from Weekly Bulletin Department of Health.

The cargoes of eight steamers, bringing shipments of Italian chestnuts, known in the trade as morrons, have been overhauled within the past six weeks. Large quantities have been condemned by the gravity process, in which the chestnuts are placed in a barrel of water and thoroughly stirred, the wormy and decomposed nuts rising to the surface and being thrown out, while those remaining at the bottom are carefully sorted.

Up to the present 1,479,160 pounds of chestnuts have been overhauled, of which 344,520 pounds have been condemned.

Recently one of the food inspectors noticed that a certain wholesaler had a quantity of dry horse-beans on sale from which numbers of a fly-like insect issued. On further investigation it was discovered that a large percentage of the individual beans held the larvæ of these flies, and their destruction was consequently ordered, although the dealer protested that they would be all right just as soon as all the "flies" had hatched.

A decision just rendered by Justice Nott of the Court of General Sessions promises greatly to impede the work of the Department of Health in prosecuting violations of the Sanitary Code and to increase the work of the already overburdened Court of Special Sessions.

Arrested for selling heroin in violation of Section 182 of the Sanitary Code, Charles P. Pray and Edward C. Peterson were sentenced in the City Magistrates' Court to serve three months in the Workhouse and pay a fine of $500 each. They appealed from the Magistrates' decision on the ground that Section 95 of the Inferior Criminal Court Act is unconstitutional. In substance, this act confers power upon a City Magistrate to summarily try and convict a defendant for a violation of the Sanitary Code. The appellants held that the constitution distinctly guaranteed either a trial by jury or, in the case of misdemeanors, trial in the Court of Special Sessions. Inasmuch as the legislature had declared violation of the sanitary code to be misdemeanors they contended that prosecutions of this kind should be conducted in the Court of Special Sessions.

Upsetting the procedure followed for years, Justice Nott of the Court of General Sessions, who heard the appeal, upheld the contention of the appellants and declared the Magistrates' Courts to

have no jurisdiction over cases of this kind. Unless reversed by a higher authority this decision practically means that hereafter all prosecutions conducted by the Department of Health for violation of the Sanitary Code will be tried in the Court of Special Sessions. This will not only add an enormous, even an intolerable burden to the work of that Court, but it will add unjustly to the inconveniences occasioned violators of minor health ordinances, such as smoking in the subway, spitting on the street, failure to muzzle dogs, etc. Hereafter persons summoned to Court on any of these charges must be held, in bail, for trial in the Court of Special Sessions. Such procedure in effect constitutes a punishment far greater than that contemplated by the legislature, and will undoubtedly give rise to serious complaints. The Corporation Counsel and the District Attorney's office are giving this serious situation the attention it deserves.

Re-argument of this case was held in the Chambers of Justice Nott on December the first. Further decision was reversed.

Pituitary Extract in Obstetrical Practice.

Physicians who are employing pituitary extract in cases of delayed paturition will be interested in this excerpt from an announcement by Parke, Davis & Co. which appears in the December issue of a contemporary:

"The clinical indications for pituitrin are such as to demand that it be of high activity. It is equally important that it be uniform in strength. Owing to unavoidable variations in the fresh glandular tissue, the amount of gland substance represented in a preparation is not an accurate index of its strength. Uniformity in therapeutic activity can be obtained only by rigid assay.

"Because of its importance in obstetrical practice we have given much attention to a detrmination of the proper strength and standardization of Pituitrin. The result of our investigations is a product of high potency, representing the average activity of 0.2 gramme of fresh posterior pituitary lobe to each Cc. of the solution. As an oxytocic Pituitrin stands without a rival. There is no more active pituitary extract.

"Pituitrin, P. D. & Co., is standardized by the two accepted methods of determining pituitary activity; the blood-pressure test and the oxytocic test, the latter by use of the isolated uterus. Every lot of Pituitrin represents the same high degree of activity."

Administered during the second stage of parturition (it should not be given during the first stage), Pituitrin is said to convert a case tedious inertia into one of normla rhytmic labor, saving time, preventing suffering, and diminishing the risk to the child which attends upon protracted labor. It is supplied in glaseptic ampoules of 1 Cc. and ½ Cc. capacity, convenient for hypodermic injection.

Items

With deepest sorrow we announce the death of our President Mr. George Merrell on Saturday the twelfth of December nineteen hundred and fourteen. The Wm. S. Merrell Chemical Co., Cincinnati.

Dr. H. Scaison of Wakefield, N. Y., has been elected master of Mount Masada Lodge F. & A. M. The doctor has a large and extensive practice in Wakefield.

Chronic Catarrhal Bronchitis.

This condition, so frequently encountered and especially so in the changeable climate of the middle and western states, is a clear indication for the continued administration of cod liver oil.

These patients, if unable to seek a more suitable climate, should be instructed carefully as to dress and bodily functions. Thus, every effort should be made to guard against exacerbations. With close attention to dress and the systematic use of cod liver oil, such as Cord. Ext. Ol. Morrhuae Comp. (Hagee), which is the preferable cod liver oil preparation by reason of its palatability and therapeutic effectiveness, the patient is employing the best means for use in this form of bronchitis.

We received a pleasant greeting from Dr. S. Robert Schultz who is taking a special post graduate course at McGill University.

Be sure and meet your Senator and Assemblyman. You may need their services a little later.

With their New Year's greeting, the Denver Chemical Co. have presented their friends with a unique desk thermometer. They have a faculty for selecting unique as well as useful articles.

For your convenience subscription blank will be found among the advertising pages of this number. Fill it out today.

The Doctors Brandenburg having returned from a long and pleasant vacation are now located at the Hotel Albert.

Book reviews have been crowded from this number. They will appear in the February number.

Read the old as well as the new advertisements in this number.

A Happy New Year to all.

FOR YOUR convenience we have placed subscription blank on page VIII. Fill it out for the year 1915 and enclose with a Dollar to the publisher, 242 West 73rd St., New York City, N. Y. It will save you the annoyance of a bill and please and gratify the publisher.

The Ductless Glands.

The therapeutic use of the DUCTLESS GLANDS is a live topic at this time.

We are able to supply limited quantities of those mentioned below, *with full assurance of their identity and quality.* Their field of usefulness has not been well defined, and the evidence so far available is mainly suggestive. In view of these facts, we supply the material without recommendation.

PARATHYROIDS (DESICCATED).

Tablets, each equivalent to 3/5 grain of the fresh gland.

Employed in such diseases as paralysis agitans, chorea, epilepsy and tetany.

PINEAL GLAND (DESICCATED).

Tablets, each equivalent to 1/2 grain of the fresh gland.

Suggested for use in treating mentally defective children, particularly in cases where there is no physical defect. Of possible value in mongolism.

ANTERIOR LOBE OF THE PITUITARY BODY (DESICCATED.)

Tablets, each containing 2 1/2 grains of the desiccated tissue.

Of possible value in peculiar disturbances of metabolism, delayed development (both mental and physical), and certain derangements of the genito-urinary system.

LITERATURE SUPPLIED ON REQUEST.

Home Offices and Laboratories,
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Parke, Davis & Co.